FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045526

Facility Name: PRESIDENTIAL PAVILION

Address: 8001 SOUTH WESTERN AVENUE (Number) CHICAGO (City) 60620 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 36-4465311

Date of Initial License for Current Owners: 10/01/01

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[X]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	218	Skilled (SNF)	218	79,570	1
2		Skilled Pediatric (SNF/PED)			2
3	110	Intermediate (ICF)	110	40,150	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	328	TOTALS	328	119,720	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,573	574	21,801	48,948	8
9	SNF/PED					9
10	ICF	69,744	292		70,036	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	96,317	866	21,801	118,984	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.39%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/01

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 53 and days of care provided 21,801

Medicare Intermediary BLUE CROSS=BLUE SHIELD

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	365,855	34,574	14,400	414,829		414,829		414,829			1
2	Food Purchase		427,411		427,411	(8,541)	418,870	(2,368)	416,502			2
3	Housekeeping	372,164	36,810		408,974		408,974		408,974			3
4	Laundry	160,509	26,842	11,274	198,625		198,625	2,583	201,208			4
5	Heat and Other Utilities			318,999	318,999		318,999	710	319,709			5
6	Maintenance	262,771	82,336	112,391	457,498		457,498	6,572	464,070			6
7	Other (specify):*			29,974	29,974		29,974	154	30,128			7
8	TOTAL General Services	1,161,299	607,973	487,038	2,256,310	(8,541)	2,247,769	7,651	2,255,420			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	3,825,977	128,112	52,266	4,006,355		4,006,355		4,006,355			10
10a	Therapy	137,690		71,320	209,010		209,010		209,010			10a
11	Activities	188,222	55,965	5,040	249,227		249,227		249,227			11
12	Social Services	206,386		3,335	209,721		209,721		209,721			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,358,275	184,077	137,961	4,680,313		4,680,313		4,680,313			16
	C. General Administration											
17	Administrative	162,444		1,223,000	1,385,444		1,385,444	(1,154,773)	230,671			17
18	Directors Fees											18
19	Professional Services			55,613	55,613		55,613	20,763	76,376			19
20	Dues, Fees, Subscriptions & Promotions			40,149	40,149		40,149	(4,974)	35,175			20
21	Clerical & General Office Expenses	313,767	25,792	185,264	524,823		524,823	(190,059)	334,764			21
22	Employee Benefits & Payroll Taxes			939,743	939,743	8,541	948,284		948,284			22
23	Inservice Training & Education							50	50			23
24	Travel and Seminar			1,710	1,710		1,710		1,710			24
25	Other Admin. Staff Transportation			11,735	11,735		11,735	1,017	12,752			25
26	Insurance-Prop.Liab.Malpractice			275,050	275,050		275,050	19,804	294,854			26
27	Other (specify):*			390,906	390,906		390,906	(377,656)	13,250			27
28	TOTAL General Administration	476,211	25,792	3,123,170	3,625,173	8,541	3,633,714	(1,685,828)	1,947,886			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,995,785	817,842	3,748,169	10,561,796		10,561,796	(1,678,177)	8,883,619			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: PRESIDENTIAL PAVILION **#0045526** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	14,400	
	REPAIRS & MAINTENANCE		0	
			0	14,400
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		11,274	
			0	11,274
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		156,955	
	ELECTRICITY		120,377	
	WATER		41,667	
	CABLE TV - LOBBY		0	
			0	318,999
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,285	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		60,354	
	ELEVATOR MAINTENANCE & REPAIR		21,546	
	OUTSIDE LABOR		210	
	EXTERMINATING SERVICE		8,127	
	FIRE SERVICE		18,869	
			0	
			0	
			0	112,391
7	**OTHER**			
	SCAVENGER		29,974	
	SECURITY SERVICE		0	29,974
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		24,600	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,093	
	PHARMACY CONSULTANT	XVIII B 39-2	15,723	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	6,000	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL CONSULTANT		4,850	
			0	52,266
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	9,021	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,899	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	56,400	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	71,320
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	5,040	
			0	5,040
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	3,335	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	3,335
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PRESIDENTIAL PAVILION **#0045526** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	1,223,000	1,223,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	19,902	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	35,711	
			0	55,613
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,600	
	EMPLOYEE WANT ADS	XIX F	14,699	
	CONTRIBUTIONS	VI 20 XIX F	1,000	
	DUES & SUBSCRIPTIONS	XIX F	13,554	
	LICENSES & PERMITS	XIX F	5,103	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,193	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	40,149
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		5,855	
	OUTSIDE CLERICAL SERVICES		88,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	190	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		3,040	
	TELEPHONE		24,345	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		63,834	185,264

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	444,530	
	UNEMPLOYMENT COMPENSATION	XIX D	151,826	
	WORKERS COMPENSATION INSURANCI	XIX D	128,607	
	HOSPITALIZATION INSURANCE	XIX D	159,512	
	EMPLOYEE BENEFITS - OTHER	XIX D	6,818	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	35,610	
	CHICAGO HEAD TAX	XIX D	12,840	939,743
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,710	
	TRAVEL	XIX G	0	
			0	
			0	1,710
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		11,735	11,735
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		275,050	275,050
27	**OTHER**			
	BAD DEBTS	VI 24	390,906	
				390,906

GRAND TOTAL COLUMN 3 OTHER 3,748,169

PRESIDENTIAL PAVILION
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	427,411	PATIENT MEALS	356952
LESS SALES TAX	(2,368)	ADD EMPLOYEE MEALS	7300
NET FOOD	425,043	TOTAL MEALS/YEAR	364252
TOTAL PATIENT CENSUS	118,984	NET FOOD	425043
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	364252
TOTAL PATIENT MEALS	356952	COST PER MEAL	1.17
		TIME EMPLOYEE MEALS	7300
ADD # EMPLOYEE MEALS/DAY	20		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	8541
TOTAL EMPLOYEE MEALS	7300		

Facility Name & ID Number PRESIDENTIAL PAVILION #0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			87,500	87,500		87,500	582,369	669,869			30
31	Amortization of Pre-Op. & Org.			780	780		780		780			31
32	Interest			29,748	29,748		29,748	874,509	904,257			32
33	Real Estate Taxes			71,680	71,680		71,680	337,591	409,271			33
34	Rent-Facility & Grounds			1,681,795	1,681,795		1,681,795	(1,381,384)	300,411			34
35	Rent-Equipment & Vehicles			57,342	57,342		57,342	9,667	67,009			35
36	Other (specify):*			25,584	25,584		25,584	146,925	172,509			36
37	**TOTAL Ownership**			1,954,429	1,954,429		1,954,429	569,677	2,524,106			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		219,648	717,251	936,899		936,899		936,899			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			179,580	179,580		179,580		179,580			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		219,648	896,831	1,116,479		1,116,479		1,116,479			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,995,785	1,037,490	6,599,429	13,632,704		13,632,704	(1,108,500)	12,524,204			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,898	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,368)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(190)	21		18
19	Entertainment		20		19
20	Contributions	(5,193)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(390,906)	27		24
25	Fund Raising, Advertising and Promotional	(1,600)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(740,859)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,122,218)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	13,718		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 13,718		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,108,500)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PRESIDENTIAL PAVILION

ID# 0045526

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1,741	6	1
2	MARKETING SALARIES	(97,266)	21	2
3	STAFF DEVELOPMENT	(63,834)	21	3
4	PHILLIP ESFORMES, INC MANAGEMENT FEES	(581,500)	17	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(740,859)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,368)	0	0	0	0	0	0	0	0	0	0	(2,368)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	2,583	0	0	0	0	0	0	0	0	2,583	4
5	Heat and Other Utilities	0	0	0	710	0	0	0	0	0	0	0	710	5
6	Maintenance	1,741	0	3,421	1,410	0	0	0	0	0	0	0	6,572	6
7	Other (specify):*	0	0	76	78	0	0	0	0	0	0	0	154	7
8	**TOTAL General Services**	(627)	0	6,080	2,198	0	0	0	0	0	0	0	7,651	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(581,500)	(587,090)	13,817	0	0	0	0	0	0	0	0	(1,154,773)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	887	19,760	116	0	0	0	0	0	0	0	20,763	19
20	Fees, Subscriptions & Promotions	(6,793)	0	1,819	0	0	0	0	0	0	0	0	(4,974)	20
21	Clerical & General Office Expenses	(161,290)	12,907	(42,242)	566	0	0	0	0	0	0	0	(190,059)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	50	0	0	0	0	0	0	0	0	50	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	147	870	0	0	0	0	0	0	0	0	1,017	25
26	Insurance-Prop.Liab.Malpractice	0	365	4,077	429	14,933	0	0	0	0	0	0	19,804	26
27	Other (specify):*	(390,906)	3,958	9,292	0	0	0	0	0	0	0	0	(377,656)	27
28	**TOTAL General Administration**	(1,140,489)	(568,826)	7,443	1,111	14,933	0	0	0	0	0	0	(1,685,828)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,141,116)	(568,826)	13,523	3,309	14,933	0	0	0	0	0	0	(1,678,177)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	18,898	0	477	2,249	560,745	0	0	0	0	0	0	582,369	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	3,731	870,778	0	0	0	0	0	0	874,509	32
33	Real Estate Taxes	0	0	0	3,499	334,092	0	0	0	0	0	0	337,591	33
34	Rent-Facility & Grounds	0	0	0	0	(1,381,384)	0	0	0	0	0	0	(1,381,384)	34
35	Rent-Equipment & Vehicles	0	741	8,425	501	0	0	0	0	0	0	0	9,667	35
36	Other (specify):*	0	0	0	(25,584)	172,509	0	0	0	0	0	0	146,925	36
37	**TOTAL Ownership**	18,898	741	8,902	(15,604)	556,740	0	0	0	0	0	0	569,677	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,122,218)	(568,085)	22,425	(12,295)	571,673	0	0	0	0	0	0	(1,108,500)	45

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				EKS MNGT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISE	LINCOLNWOOD	MNGT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	EMI	$ 611,500	EMI ENTERPRISES, INC		$	$ (611,500)	1
2	V								2
3	V								3
4	V	17	OFFICER'S SALARY				24,410	24,410	4
5	V	19	ACCOUNTING FEES				887	887	5
6	V	21	OFFICE EXPENSE				12,907	12,907	6
7	V	25	TRANSPORTATION				147	147	7
8	V	26	INSURANCE				365	365	8
9	V	27	EMPLOYEE BENEFITS				3,958	3,958	9
10	V	35	AUTO LEASE				741	741	10
11	V								11
12	V								12
13	V								13
14	Total			$ 611,500			$ 43,415	$ * (568,085)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 88,000	EKS MANAGEMENT		$	$ (88,000)	15
16	V								16
17	V	4	HOUSEKEEPING SALARIES				2,565	2,565	17
18	V	4	CLEANING SUPPLIES				18	18	18
19	V	6	PAINTERS SALARIES				3,421	3,421	19
20	V	7	SCAVENGER				76	76	20
21	V	17	C F O SALARY				13,817	13,817	21
22	V	19	PROFESSIONAL FEES				19,760	19,760	22
23	V	20	WANT ADS/ BACK GR CKS				1,819	1,819	23
24	V	21	OFFICE EXPENSE				45,758	45,758	24
25	V	23	SEMINARS				50	50	25
26	V	25	TRANSPORTATION				870	870	26
27	V	26	INSURANCE				4,077	4,077	27
28	V	27	EMPLOYEE BENEFITS				9,292	9,292	28
29	V	30	DEPRECIATION				477	477	29
30	V	35	EQUIPMENT RENT				8,425	8,425	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 88,000			$ 110,425	$ * 22,425	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 25,584	IME REALTY		$	$ (25,584)	15
16	V								16
17	V								17
18	V	5	UTILITIES				710	710	18
19	V	6	REPAIRS / MAINTENANCE				1,410	1,410	19
20	V	7	ALARM SERVICE				78	78	20
21	V	19	PROFEESIONAL FEES				116	116	21
22	V	21	OFFICE EXPENSE				566	566	22
23	V	26	INSURANCE				429	429	23
24	V	30	DEPRECIATION				2,249	2,249	24
25	V	32	INTEREST				3,731	3,731	25
26	V	33	R/E TAX				3,499	3,499	26
27	V	35	STORAGE FEES				501	501	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 25,584			$ 13,289	$ * (12,295)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 1,381,384	BEVERLY PAVILION LLC		$	$ (1,381,384)	15
16	V	26	INSURANCE				14,933	14,933	16
17	V	30	DEPR. S.L BUILDING				502,320	502,320	17
18	V	30	DEPR. S.L EQUIP				58,425	58,425	18
19	V	32	INTEREST				870,778	870,778	19
20	V	33	REAL ESTATE TAXES				334,092	334,092	20
21	V	36	M.I.P. INSURANCE				172,509	172,509	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,381,384			$ 1,953,057	$ * 571,673	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	MORRIS ESFORMES	MEMBER	ADMIN.	40.00	SEE			MNMT FEE	$ 24,410	17-7	1
2					ATTACHED						2
3	PHILIP ESFORMES	MEMBER	ADMIN.	40.00	SCHEDULE			MNMT FEE	30,000	17-7	3
4											4
5	ARUM WEINFELD		CFO	3.00				SALARY	13,817	17-7	5
6											6
7											7
8	MICHAEL ROSEN	ADMINISTRATOR		3.00				SALARY	162,444	17-1	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 230,671		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER SALARY	PATIENT DAYS	901,761	15	$ 185,000	$ 185,000	118,984	$ 24,410	1
2	19	ACCOUNTING FEES	PATIENT DAYS	901,761	15	6,725		118,984	887	2
3	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	97,823	79,576	118,984	12,907	3
4	25	TRANSPORTATION	PATIENT DAYS	901,761	15	1,114		118,984	147	4
5	26	INSURANCE	PATIENT DAYS	901,761	15	2,768		118,984	365	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	29,997		118,984	3,958	6
7	35	AUTO LEASE	PATIENT DAYS	901,761	15	5,617		118,984	741	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 329,044	$ 264,576		$ 43,415	25

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	901,761	15	$ 19,441	$ 19,441	118,984	$ 2,565	1
2	4	CLEANING SUPPLIES	PATIENT DAYS	901,761	15	140		118,984	18	2
3	6	PAINTERS SALARY	PATIENT DAYS	901,761	15	25,925	25,925	118,984	3,421	3
4	7	SCAVENGER	PATIENT DAYS	901,761	15	573		118,984	76	4
5	17	C F O SALARY	PATIENT DAYS	901,761	15	104,714	104,714	118,984	13,817	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	901,761	15	149,759		118,984	19,760	6
7	20	WANT ADS / BCK GRND CKS	PATIENT DAYS	901,761	15	13,787		118,984	1,819	7
8	21	OFFICE EXPENSE	PATIENT DAYS	901,761	15	346,792	248,929	118,984	45,758	8
9	23	SEMINARS	PATIENT DAYS	901,761	15	380		118,984	50	9
10	25	TRANSPORTATION	PATIENT DAYS	901,761	15	6,593		118,984	870	10
11	26	INSURANCE	PATIENT DAYS	901,761	15	30,900		118,984	4,077	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	70,423		118,984	9,292	12
13	30	DEPRECIATION	PATIENT DAYS	901,761	15	3,617		118,984	477	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	901,761	15	63,848		118,984	8,425	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 836,892	$ 399,009		$ 110,425	25

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	346,361	15	$ 9,618	$	25,584	$ 710	1
2	6	REPAIRS / MAINT	INCOME	346,361	15	19,083		25,584	1,410	2
3	7	ALARM SERVICE	INCOME	346,361	15	1,056		25,584	78	3
4	19	PROFESSIONAL FEES	INCOME	346,361	15	1,575		25,584	116	4
5	21	OFFICE EXPENSE	INCOME	346,361	15	7,666		25,584	566	5
6	26	INSURANCE	INCOME	346,361	15	5,806		25,584	429	6
7	30	DEPRECIATION	INCOME	346,361	15	30,446		25,584	2,249	7
8	32	INTEREST	INCOME	346,361	15	50,514		25,584	3,731	8
9	33	R/E TAX	INCOME	346,361	15	47,364		25,584	3,499	9
10	35	STORAGE FEES	INCOME	346,361	15	6,785		25,584	501	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 179,913	$		$ 13,289	25

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BEVERLY PAVILION LLC
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847)674-5795
Fax Number: (847)674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	INSURANCE	DIRECT	1	1	$ 14,933	$	1	$ 14,933	1
2	30	DEPR. S.L. BUILDING	DIRECT	1	1	502,320		1	502,320	2
3	30	DEPR. S.L. EQUIP	DIRECT	1	1	58,425		1	58,425	3
4	32	INTEREST	DIRECT	1	1	870,778		1	870,778	4
5	33	REAL ESTATE TAXES	DIRECT	1	1	334,092		1	334,092	5
6	36	M.I.P. INSURANCE	DIRECT	1	1	172,509		1	172,509	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,953,057	$		$ 1,953,057	25

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CAMBRIDGE		X	MORTGAGE	$99,236.00	3/10/05	$ 18,706,800	$ 18,584,442			$ 815,150	1
2	WEDGEWOOD REALTY		X	MORTGAGE	$15,000.00	3/10/05	1,650,600	1,440,825	11/10/15	4.5000	55,628	2
3												3
4												4
5	RELATED PARTY										3,731	5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL	INTEREST	REVOLV		400,000	REVOLV	PRIME+	29,748	6
7												7
8												8
9	TOTAL Facility Related				$114,236.00		$ 20,357,400	$ 20,425,267			$ 904,257	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 20,357,400	$ 20,425,267			$ 904,257	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 172,509 Line # 36

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 326,832	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 334,092	2
3. Under or (over) accrual (line 2 minus line 1).	$ 7,260	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 64,420	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 71,680	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000		8
2001	83,725	9
2002	335,896	10
2003	326,832	11
2004	334,092	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESIDENTIAL PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0045526

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-31-108-044-0000	NURSING HOME	$ 334,091.67	$ 334,091.67
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 334,091.67	$ 334,091.67

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,056 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 7+ BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 3,900 2. Number of Years Over Which it is Being Amortized: 5 YRS

3. Current Period Amortization: 780 4. Dates Incurred: 10/01/01

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2005	$ 1,500,000	1
2					2
3	TOTALS			$ 1,500,000	3

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	328		2005		$ 17,449,000	$ 502,320	27.5	$ 502,320	$	$ 502,320	4
5											5
6											6
7	RELATED PARTY				75,472	2,161		2,161			7
8											8
	Improvement Type**										
9	AWNINGS			2001	10,500	382	27.5	382		1,576	9
10	FENCE			2001	2,100	140	15	140		578	10
11	ELEVATOR			2001	18,340	667	27.5	667		2,751	11
12	ALARM			2001	5,686	207	27.5	207		854	12
13	WINDOWS			2001	4,149	151	27.5	151		623	13
14	BOILER			2001	3,000	109	27.5	109		232	14
15	FURNISHINGWALLPAPER & BORDERS			2001	12,953	971	5	1,204	233	12,953	15
16	KITCHEN SINK & DRAIN			2001	2,525	92	27.5	92		379	16
17	DOORS			2001	15,100	549	27.5	549		2,254	17
18	ELEVATOR			2002	222,811	8,102	27.5	8,102		32,408	18
19	FENCE			2002	3,100	207	15	207		725	19
20	DOORS & LOCKS			2002	21,741	791	27.5	791		3,065	20
21	SHOWER ROOMS			2002	4,669	170	27.5	170		560	21
22	ALARM AND SPRINKLER			2002	11,881	432	27.5	432		1,421	22
23	EJECTOR & SEWEGE PUMP			2002	14,604	531	27.5	531		1,748	23
24	ROOF DRAIN			2002	3,100	113	27.5	113		400	24
25	FURNISHING - CARPETS AND DRAPERIES			2002	91,494	7,378	5	18,299	10,921	64,046	25
26	ELEVATIR			2003	110,562	4,020	27.5	4,020		11,223	26
27	PARKING LOT			2003	64,182	4,279	15	4,279		10,698	27
28	FIRE ALARM SYSTEM			2003	25,000	909	27.5	909		2,310	28
29	ROOF			2003	26,500	964	27.5	964		2,370	29
30	EXTERIOR WALL			2003	9,796	356	27.5	356		846	30
31	SINKS			2003	3,146	114	27.5	114		290	31
32	BUILT IN WARDROBE			2003	19,398	705	27.5	705		1,616	32
33	REBUILD A/C & HEATING RETURN FAN			2004	4,700	171	27.5	171		321	33
34	FIRE ALARM SYSTEM			2004	13,201	480	27.5	480		860	34
35	BUILT IN WARDROBE			2004	21,807	793	27.5	793		1,223	35
36	MASONRY REPAIRS			2004	61,620	2,241	27.5	2,241		2,895	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DOORS	2004	$ 2,995	$ 109	27.5	$ 109	$	$ 132	37
38	BOILER REPAIR	2004	5,650	206	27.5	206		214	38
39	HOT WATER HEATER	2004	5,756	209	27.5	209		218	39
40	FLOOR TILING	2004	5,326	194	27.5	194		202	40
41	REMODEL BATHROOM	2005	6,080	120	27.5	120		120	41
42	DOORS	2005	4,506	89	27.5	89		89	42
43	FLOOR TILING	2005	1,536	30	27.5	30		30	43
44	2 WATER BOILERS	2005	99,047	1,051	27.5	1,051		1,051	44
45	CONCRETE PATIO	2005	3,015	126	15	126		126	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 18,466,048	$ 542,639		$ 553,793	$ 11,154	$ 665,727	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 568,352	$ 48,338	$ 56,835	$ 8,497	10 YRS	$ 210,461	71
72	Current Year Purchases	5,022	1,004	251	(753)	10 YRS	251	72
73	Fully Depreciated Assets							73
74	RELATED PARTIES	738,000	58,990	58,990				74
75	TOTALS	$ 1,311,374	$ 108,332	$ 116,076	$ 7,744		$ 210,712	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 21,277,422	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 650,971	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 669,869	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 18,898	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 876,439	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: WEDGEWOOD NURSING PAVILION REALTY, LLLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		328	10/01/01	$ 1,681,795			3
4	Additions							4
5								5
6								6
7	TOTAL		328		$ 1,681,795 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning 10/01/01
Ending 09/30/08

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 16,899 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		SEE SCHEDULE	$	$ 40,443	17
18					18
19					19
20					20
21	TOTAL		$	$ 40,443	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	$		$ 536,690	$		$ 536,690	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			1,964			1,964	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			178,597			178,597	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				199,098		199,098	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-8					20,550		20,550	13
14	TOTAL			$		$ 717,251	$ 219,648		$ 936,899	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number PRESIDENTIAL PAVILION **#** 0045526 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 202,728	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (600,000))	3,621,356		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	162,254		6
7	Other Prepaid Expenses	21,375		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,007,713	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	837,129		15
16	Equipment, at Historical Cost	677,821		16
17	Accumulated Depreciation (book methods)	(682,346)		17
18	Deferred Charges	37,600		18
19	Organization & Pre-Operating Costs	3,900		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,315)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 870,789	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,878,502	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 351,518	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	400,000		29
30	Accrued Salaries Payable	135,745		30
31	Accrued Taxes Payable (excluding real estate taxes)	35,054		31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,420		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 986,737	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	314,500		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 314,500	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,301,237	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,577,265	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,878,502	$	48

***(See instructions.)**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,187,075	1
2	Restatements (describe):		2
3	ROUNDING	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,187,078	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,638,859	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,248,672)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 390,187	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,577,265	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,181,555	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,181,555	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	107,248	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 107,248	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,288,803	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,256,310	31
32	Health Care	4,680,313	32
33	General Administration	3,625,173	33
	B. Capital Expense		
34	Ownership	1,954,429	34
	C. Ancillary Expense		
35	Special Cost Centers	936,899	35
36	Provider Participation Fee	179,580	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,632,704	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,656,099	41
42	**Income Taxes**	(17,240)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,638,859	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,555	3,875	$ 182,881	$ 47.20	1
2	Assistant Director of Nursing	848	868	26,260	30.25	2
3	Registered Nurses	7,142	7,452	182,623	24.51	3
4	Licensed Practical Nurses	70,053	73,630	1,530,750	20.79	4
5	CNAs & Orderlies	169,887	184,516	1,636,046	8.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,812	12,984	137,690	10.60	8
9	Activity Director					9
10	Activity Assistants	23,382	24,444	188,222	7.70	10
11	Social Service Workers	15,611	16,590	206,386	12.44	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,708	42,088	365,855	8.69	15
16	Dishwashers					16
17	Maintenance Workers	31,379	32,639	262,771	8.05	17
18	Housekeepers	43,823	47,160	372,164	7.89	18
19	Laundry	17,205	19,905	160,509	8.06	19
20	Administrator	2,085	2,407	162,444	67.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	27,039	28,210	313,767	11.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,247	5,585	56,116	10.05	31
32	Other Health C: MDS, nrsg clerical	9,279	9,855	211,301	21.44	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	475,055	512,208	$ 5,995,785 *	$ 11.71	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 14,400	1-3	35
36	Medical Director	MONTHLY	6,000	9-3	36
37	Medical Records Consultant	MONTHLY	1,093	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	15,723	10-3	39
40	Physical Therapy Consultant	MONTHLY	9,021	10a-3	40
41	Occupational Therapy Consultant	MONTHLY	5,899	10a-3	41
42	Respiratory Therapy Consultant	MONTHLY	56,400	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	MONTHLY	5,040	11-3	44
45	Social Service Consultant	MONTHLY	3,335	12-3	45
46	Other(specify) DENTAL	MONTHLY	4,850	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 121,761		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MICHAEL ROSEN	ADMIN	3%	$ 162,444
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 162,444

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 611,500
PHILIP ESFORMES, INC	611,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,223,000

(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		55,613
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 55,613

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 128,607
Unemployment Compensation Insurance	151,826
FICA Taxes	444,530
Employee Health Insurance	159,512
Employee Meals	8,541
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	6,818
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	35,610
CHICAGO HEAD TAX	12,840
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 948,284

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	14,699
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	1,600
TRUST/FRANCHISE/CONTRIB/ETC	5,193
LICENSES & PERMITS	3,113
DUES & SUBSCRIPTIONS	13,554
MGMT CO ALLOCATION	1,819
TRUST/FRANCHISE/CONTRIB/ETC	(5,193)
Less: Public Relations Expense	(0)
Non-allowable advertising	(1,600)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,175

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	1,710
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,710

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	2002	$ 10,449	3 YRS	$ 1,742	$ 3,483	$ 3,483	$ 1,741	$	$	$	$	$
2													
3													
4													
5													
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19													
20	TOTALS		$ 10,449		$ 1,742	$ 3,483	$ 3,483	$ 1,741	$	$	$	$	$

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $13,519**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **1,900** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **179,580**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **8,541** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees